Healthcare Reform's Mandatory Medical Loss Ratio: Constitutionality, Policy, and Implementation

By WESLEY D. MARKHAM*

> The business [the insurance companies are] in is health insurance for a profit. They are trying to insure as many people as they can as affordably as they can so that they make a profit and so that the patients get covered. Obama is wiping the profit out. Obama is purposely trying to destroy the private health insurance industry so that government's the only option people have, five, ten years from now. That's the objective. And by telling them that they must devote 80% of their profits to X? He's got no right to do that. It's totally unconstitutional.
>
> —Rush Limbaugh, noted conservative pundit, on the medical loss ratio ("MLR")[1]

> In effect, the onerous obligations under the Reid Bill, [an earlier version of the Patient Protection and Affordable Care Act with similar MLR provisions], would convert private health insurance companies into virtual public utilities. This action is not only a source of real anxiety but also a decision of constitutional proportions, for it systematically strips the regulated health-insurance issuers of their constitutional entitlement to earn a reasonable rate of return on the massive amounts of capital that they have already invested in building out their businesses.
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> —Richard Epstein, prominent legal scholar, on the MLR[2]

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1. Alex Toole, *"Rush"ing to Conclusions. . .Without the Evidence*, 2028BLOG (Feb. 1, 2011), http://2028blog.com/2011/02/01/196/ (quoting Rush Limbaugh's Jan 17, 2011 broadcast).

2. Richard A. Epstein, *Impermissible Ratemaking in Health-Insurance Reform: Why the Reid Bill is Unconstitutional* 2 (Univ. of Chi. Law & Econ., Olin, Working Paper No. 506, 2009; Univ. of Chi., Pub. Law, Working Paper No. 288, 2009), available at http://ssrn.com/abstract=1527128 (analyzing the constitutionality of the first version of the Patient Protection and Affordable Care Act, also known as the "Reid Bill").

Introduction

AS A GENERAL RULE, I do not give much credence to Rush Limbaugh's interpretation of the law. However, when Richard Epstein shares his view, perhaps there's something to it. Both Limbaugh and Epstein oppose the medical loss ratio ("MLR") provisions in the recently enacted healthcare reform legislation, and after investigating the matter myself, I can see their point. This Article attempts to bring public and congressional attention to the often-overshadowed MLR issue. If Congress revisits healthcare reform in the coming years, our legislators should leave the MLR mandate out of any new law. Imposing a nationwide, mandatory MLR on the health insurance industry is bad policy and likely unconstitutional.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act ("ACA")[3] into law.[4] The New York Times heralded the new legislation as "landmark health care overhaul—the most expansive social legislation enacted in decades."[5] As Vice President Joe Biden less eloquently put it, "this is a big [expletive] deal."[6] The ACA is certainly a big deal, but at 906 pages in length, it's also just plain big.[7] And like any big bill that revamps something as critical as healthcare, the ACA has problems. Imposing a mandatory MLR on private health insurance providers is one of those problems.

In a broad sense, the ACA's various provisions can be analyzed along two axes: constitutionality and policy. Some provisions are undoubtedly both constitutional and good policy. The drastic expansion of Medicaid[8] and the creation of health insurance exchanges[9] fall

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter ACA].

4. *See* Sheryl Gay Stolberg & Robert Pear, *A Stroke of a Pen, Make That 20, and It's Official*, N.Y. TIMES, Mar. 23, 2010, at A19.

5. *Id.*

6. *Id.* (quoting Vice President Biden whispering congratulations to President Obama).

7. *See generally* ACA, 124 Stat. at 119–1024.

8. *See* GEORGETOWN UNIV. CTR. FOR CHILDREN & FAMILIES, SUMMARY OF MEDICAID, CHIP, AND LOW-INCOME PROVISIONS IN HEALTH CARE REFORM 2–3 (2010) [hereinafter *Summary*], *available at* http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/health%20reform/health%20reform%20summary.pdf (indicating that the health reform will expand Medicaid coverage for children, non-elderly adults, and elderly adults if their individual or family income is below given percentages of the federal poverty level).

9. *See Initial Guidance to States on Exchanges*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html (last visited Apr. 11, 2011) ("An Exchange is a mechanism for organizing the health insurance

within this category. Other provisions may embody sound policy decisions but arguably overstep the constitutional line. The individual mandate is the paradigmatic example.[10] Still other provisions might be both unconstitutional and bad policy. The ACA's MLR mandate is just such a provision.

Part I of this Article presents an overview of the ACA's MLR provisions, as well as the current controversy surrounding these new requirements. Part II evaluates, and ultimately questions, the constitutionality of the MLR provisions. Part III sets forth policy-based arguments for and against setting a mandatory MLR in the health insurance industry, proposing that the ACA will detrimentally "anchor" insurance providers to the arbitrary minimum MLR required by the law. This anchoring will simultaneously cause "low MLR" providers to raise their MLRs to comply with the law (the intended effect of the law) *and* "high MLR" providers to drift downward towards the new, national MLR standard (an unintended negative consequence of the law). Finally, Part IV details the practical steps that insurance providers, state governments, and the federal government should take to implement the new MLR laws.

I. The ACA's MLR Mandate: Overview and Current Events

A. The MLR Under the ACA

In general terms, a health insurance company's "medical loss ratio" is the percentage of premium revenue the company spends on "direct care for patients and efforts to improve care quality."[11] A short hypothetical will illustrate the MLR calculation. Suppose Health Insurance Company X insures 100 consumers, and each consumer pays the company $10,000 per year for his coverage. It follows that Company X's premium revenue for the year totals $1,000,000.[12] If Company X

marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.").

10. *See generally State Legislation and Actions Challenging Certain Health Reforms, 2011*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/?tabid=18906 (last visited Apr. 11, 2011) (summarizing the legislative efforts and judicial proceedings challenging the individual mandate).

11. *Medical Loss Ratio*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ociio/regulations/medical_loss_ratio.html (last visited Apr. 12, 2011).

12. 100 customers multiplied by $10,000 per year equals $1,000,000 per year.

pays out $700,000 to cover its 100 consumers' annual medical expenses, then the company's MLR equals 70%.[13]

The ACA sets, for the first time, nationwide minimum MLR requirements that all health insurance issuers must meet.[14] The ACA's MLR legislation contains several important interlocking provisions. First, the new law requires each health insurance issuer to submit an annual report to the Secretary of Health and Human Services ("SHHS") detailing how the issuer spends its money.[15] Specifically, the report must include the percentage of total premium revenue the issuer spends ''(1) on reimbursement for clinical services provided to enrollees under such coverage; (2) for activities that improve health care quality; and (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees."[16] In other words, issuers must report their MLRs to the federal government.

Second, and most importantly, the ACA mandates that every health insurance issuer maintain its MLR above a certain benchmark: 85% in the large group market and 80% in the small group and individual markets.[17] The ACA calculates the MLR as the "ratio of the amount of premium revenue expended by the issuer on [reimbursement for clinical services and activities that improve health care quality] to the total amount of premium revenue [after various exclusions]."[18] If an insurance company's MLR falls below the 80% or 85% threshold, the company must send rebates to the people it insures.[19]

Clearly, the MLR calculation, and therefore an insurance provider's compliance with the law, depends heavily on the definition of

13. $700,000 in direct care for patients divided by $1,000,000 in total premium revenue equals 70%.

14. *See* ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 885–87 (2010) (amending Public Health Service Act § 2718, codified as amended at 42 U.S.C. § 300gg-18)).

15. *Id.* at 885–86 (amending Public Health Service Act § 2718(a), codified as amended at 42 U.S.C. 300gg-18).

16. *Id.*

17. *Id.* at 886 (amending Public Health Service Act § 2718(b)(1)(A), 42 U.S.C. 300gg-18). The large group market includes group health plans maintained by employers having "an average of at least 101 employees." *Id.* § 1304(b)(1), 124 Stat. at 172. The small group market includes group health plans maintained by employers having "at least 1 but not more than 100 employees." *Id.* § 1304(b)(2), 124 Stat. at 172. The individual market includes health insurance plans offered to individuals outside of the aforementioned group health plans. *See id.* § 1304(a), 124 Stat. at 171.

18. *Id.* § 10101(f), 124 Stat. at 886 (amending Public Health Service Act § 2718(b)(1)(A), codified as amended at 42 U.S.C. 300gg-18).

19. *Id.*

vague terms such as "activities that improve health care quality."[20] Uncertainty is costly, especially for businesses that must structure their operations to conform to a web of government regulations. Anticipating this potential problem, Congress required the National Association of Insurance Commissioners ("NAIC") to define the activities that would improve health care quality and thus fall within the numerator of the MLR equation.[21]

Under the ACA, each state has the option to raise its own minimum MLR requirements above the federal benchmarks.[22] Congress directs the states to "seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements" when determining the appropriate MLR.[23] This statutory language suggests that Congress sought to accommodate several competing policy goals by enacting a minimum MLR requirement: *participation* by insurance providers, *competition* among insurance providers, and *value* for health insurance consumers. The ACA's minimum MLR provision went into effect on January 1, 2011.[24]

Through its complicated language, the ACA's MLR legislation produces a simple result: capping insurance company profits. Suppose an insurance company has absolutely no expenses—an entirely unrealistic assumption for any business, but useful for purposes of explanation. The ACA caps the company's profit margin at 15% in the large group market and 20% in the small group and individual markets. More realistically, if the company spends 10% of its premium revenue on administrative costs, then the ACA effectively limits the company's profit margin to 5% in the large group market and 10% in the small group and individual markets. In an extreme example, consider a company that cannot, or will not, reduce its administrative costs to below 20% of its revenue. The ACA's MLR provisions ensure that this company will make *no profit* in the small group and individual markets and will *lose 5%* in the large group market, essentially forcing

20. *Id.*

21. *Id.* at 887 (amending Public Health Service Act § 2718(c), codified as amended at 42 U.S.C. 300gg-18).

22. *Id.* at 886 (amending Public Health Service Act § 2718(b)(1)(A), codified as amended at 42 U.S.C. 300gg-18).

23. *Id.* at 887 (amending Public Health Service Act § 2718(b)(2), codified as amended at 42 U.S.C. 300gg-18).

24. *Id.* at 886 (amending Public Health Service Act § 2718(b)(1)(A), codified as amended at 42 U.S.C. 300gg-18).

the company out of business. This profit capping represents a severe, potentially unconstitutional, intrusion into the private health insurance industry, a topic developed in detail in Part II below.

To mitigate the new MLR law's harsh effects discussed in the immediately preceding paragraph, the ACA does provide a "safety valve" to alleviate some of the foreseeable problems associated with the MLR requirements. Specifically, the SHHS has discretion to adjust the MLR benchmark rates in two situations: (1) in the small group and individual markets of a state, "if the Secretary determines that [an 80% MLR] may destabilize the individual market in such State;"[25] and (2) "if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges."[26] Neither of these safety valves applies to the large group market, and both vest ultimate authority in the SHHS.

To qualify for the MLR adjustment under the first safety valve, "a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers."[27] As of September 12, 2011, sixteen states (Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, Louisiana, Kansas, Delaware, Indiana, Michigan, Texas, Oklahoma, and North Carolina) and the territory of Guam have requested MLR adjustments.[28] Maine's request was granted on March 8, 2011;[29] New Hampshire's and Nevada's requests were partially granted on May 13, 2011;[30] Kentucky's and

25. *Id.* (amending Public Health Service Act § 2718(b)(1)(A)(ii), codified as amended at 42 U.S.C. 300gg-18).

26. *Id.* at 887 (amending Public Health Service Act § 2718(d), codified as amended at 42 U.S.C. 300gg-18).

27. *Medical Loss Ratio*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, http://cciio.cms.gov/programs/marketreforms/mlr/index.html (last visited Apr. 12, 2011) [hereinafter CTR. FOR CONSUMER INFO. & INS. OVERSIGHT].

28. *Id.*

29. Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Mila Kofman, Me. Superintendent of Ins., at 2, 18 (Mar. 8, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/maine/maine_decision_letter_3_8_11.pdf.

30. Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Roger A. Sevigny, Comm'r N.H. Ins. Dep't, at 2, 18 (May 13, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/nh_mlr_adj_decletter.pdf (authorizing a MLR reduction in New Hampshire to 72% in 2011, 75% in 2012, and the 80% statutory standard in 2013, despite New Hampshire's request for a reduction to 70% from 2011 through 2013); Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Brett J. Barrett, Nev. Comm'r Ins., at 2, 12 (May 13, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/nevada/

Iowa's requests were partially granted on July 22, 2011;[31] North Dakota's and Delaware's petitions were denied on July 22, 2011 and September 9, 2011, respectively;[32] and the other ten requests remain pending.[33]

Pursuant to the statute,[34] the Department of Health and Human Services ("HHS") promulgated regulations regarding the implementation of the ACA's MLR requirements.[35] Like the ACA itself, these regulations are long (seventy-two pages) and complicated.[36] According to the HHS, "[t]he medical loss ratio regulation outlines disclosure and reporting requirements, how insurance companies will calculate their medical loss ratio and provide rebates, and how adjustments could be made to the medical loss ratio standard to guard against market destabilization."[37] The regulations closely track the recommendations formulated by the NAIC "after months of meetings and debate involv-

mlr_adj_decision_letter_5_13_11.pdf (approving a MLR reduction in Nevada to 75% in 2011, despite Nevada's request for a reduction to 72% in 2011).

31. Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Sharon P. Clark, Ky. Comm'r Ins., at 2, 13 (July 22, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/Kentucky/ky_mlr_adj_determination_letter.pdf (authorizing a MLR reduction in Kentucky to 75% in 2011 and the 80% statutory standard of in 2013, despite Kentucky's request for a reduction to 65%, 70%, and 75% for 2011, 2012, and 2013, respectively); Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Susan E. Voss, Iowa Comm'r Ins., at 2, 11 (July 22, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/iowa/ia_mlr_adj_determination_letter.pdf (authorizing a MLR reduction in Iowa to 67% in 2011, 75% for 2012, and the 80% statutory standard in 2013, despite Iowa's request for a reduction to 60%, 70%, and 75% for 2011, 2012, and 2013, respectively).

32. Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Adam W. Hamm, N.D. Ins. Comm'r, at 2, 10–11 (July 22, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/northdakota/nd_mlr_adj_determination_letter.pdf; Letter from Steven B. Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Karen Weldin Stewart, Del. Comm'r, at 2, 10 (Sept. 9, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/delaware/de_mlr_adj_determination_letter.pdf.

33. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 27.

34. ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 887 (2010) ("The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.")) (amending Public Health Service Act § 2718(b)(3), codified as amended at 42 U.S.C. 300gg-18).

35. Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act (Interim Final Rule), 75 Fed. Reg. 74,864 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Regulations], *available at* http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf].

36. *See id.*

37. *New Affordable Care Act Rules Give Consumers Better Value for Insurance Premiums*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Nov. 22, 2010), http://www.hhs.gov/news/press/2010pres/11/20101122a.html.

ing industry and consumer representatives."[38] As a general matter, consumer advocates praised the regulations, while insurance companies criticized them.[39]

A comprehensive review of the MLR regulations is beyond the scope of this Article. However, it is worth mentioning several of the more important and controversial aspects of the regulations to provide background for the in-depth constitutional and policy-based discussions that follow. First, the regulations make special allowances for "mini-med" plans, i.e., limited-benefit policies that only cover up to $250,000 a year.[40] In essence, mini-med plans can satisfy the 80% MLR requirement by spending only 40% on medical costs.[41] Consumer advocates detest these mini-med plans, claiming that they "[leave] often unsuspecting customers to fend for themselves if they develop a costly and serious disease."[42]

Second, the regulations spell out which expenses "count" as medical spending for the purposes of calculating the MLR. Naturally, the insurance industry advocated for a broad definition of activities that improve health care quality.[43] The broader the definition, the easier it is to meet the minimum MLR requirement. In particular, insurers lobbied to include "the cost of paying claims, signing up doctors to their networks or running customer service call centers" in the numerator of the MLR equation.[44] Ultimately, the regulations disappointed the health insurance industry. While the regulations permit insurers to count certain quality improvement costs and payments to health care providers (doctors, nurses, and hospitals) as medical expenses, the regulations classify broker commissions as administrative costs, which are excluded from the MLR numerator.[45]

38. Julie Appleby, *New Law's Health Insurance Regulations Could Mean Rebates For Consumers*, KAISER HEALTH NEWS (Nov. 22, 2010), http://www.kaiserhealthnews.org/Stories/2010/November/22/mlr-sebelius-medical-loss-ratio-insurance.aspx.

39. *See id.*

40. *Id.*

41. *Id.*

42. N.C. Aizenman & Robert Barnes, *Controversial "Mini-med" Plans to Get Reprieves Through Waivers*, WASH. POST, Mar. 27, 2011, at A15.

43. Appleby, *supra* note 38.

44. *Id.*

45. *Id.*; *accord* Katherine Hobson, *HHS Releases Final Medical Loss Ratio Regulations*, WALL ST. J. HEALTH BLOG (Nov. 22, 2010, 9:54 AM), http://blogs.wsj.com/health/2010/11/22/hhs-releases-final-medical-loss-ratio-regulations/.

B. Current Controversy: What's In and What's Out?

The definitional distinction between medical and non-medical expenses drives the MLR debate.[46] An insurance company's costs associated with "activities that improve health care quality" count towards the 80% or 85% MLR requirements; non-medical, administrative expenses do not. Three categories of expenses have drawn especially heavy scrutiny: (1) brokers' commissions, discussed briefly above, (2) federal and state taxes, and (3) anti-fraud efforts.

1. Brokers' Commissions

Insurance brokers "are independent agents who receive commissions from an insurer for selling insurance products."[47] Brokers provide a valuable service to both health insurance issuers and health insurance consumers. For example, brokers (1) help employers design the "right" plan(s) for their employees; (2) comparison shop to get the best possible price for their clients; (3) explain the costs and benefits of the plan(s) to the insured; (4) resolve claims-related problems; and (5) refer customers to health insurance providers, thereby allowing the insurance companies to limit marketing-related expenses.[48]

Health insurance brokers lobbied to have their commissions excluded from the MLR equation.[49] Specifically, the brokers expressed concern that if their commissions counted as administrative expenses in the MLR calculation, "insurers would cut their pay to improve medical loss ratios."[50] The brokers' concerns appear warranted. Facing the prospect of a mandatory minimum MLR, many health insurance issuers have already reduced broker commissions by up to 50%.[51] Additionally, state insurance agencies worried that they would be flooded with calls for help if the MLR pushed too many brokers out of business.[52] Nonetheless, the brokers lost this battle, at least for the time

46. *See* Jennifer Haberkorn, *Health Policy Brief, Updated: Medical Loss Ratios*, HEALTH AFFAIRS (Nov. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33 (discussing the MLR debate).

47. LESLIE J. CONWELL, CTR. FOR STUDYING HEALTH SYS. CHANGE, THE ROLE OF HEALTH INSURANCE BROKERS 2 (2002).

48. *See id.*

49. *See* Haberkorn, *supra* note 46.

50. *Id.*

51. Bob Graham, *Agents Say Their Commissions Should Be Exempt Medical Loss Ratios*, INS. & FIN. ADVISOR (Feb. 22, 2011), http://ifawebnews.com/2011/02/22/agents-say-their-commissions-should-be-exempt-medical-loss-ratios/.

52. Haberkorn, *supra* note 46.

being. While the NAIC decided to count commissions as administrative expenses,[53] it also established a working group with HHS to "ensure that the vital role of agents and brokers is preserved."[54]

2. Federal and State Taxes

According to the ACA, the denominator of the MLR equation is "the total amount of premium revenue (*excluding Federal and State taxes and licensing or regulatory fees*)."[55] A smaller denominator makes the MLR requirement easier to meet. Therefore, insurance companies naturally want to exclude as many taxes and fees as possible. The NAIC took the position that "all federal taxes, such as income taxes, except for taxes on investment income and capital gains" should be excluded from the MLR denominator.[56] This relatively broad definition favors the health insurance providers.

On the other hand, the drafters of the bill maintained that the provision "refer[s] only to Federal taxes and fees that relate specifically to revenue derived from the provision of health insurance coverage that were included in the [ACA]."[57] In other words, this provision includes only federal taxes on insurers that result from implementing the new law and excludes any other taxes. By excluding far fewer taxes, this relatively narrow definition would make it more difficult for insurance companies to meet the ACA's minimum MLR requirements. Some critics of this position claim that such a narrow definition of the tax exclusion would amount to double-taxation of the health insurance industry.[58] Ultimately, HHS, empowered by statute

53. *Id.*

54. Letter from Jane Cline, Nat'l Assoc. of Ins. Comm'rs, et al., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Oct. 27, 2010), http://naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

55. ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 886 (2010) (emphasis added) (amending Public Health Service Act § 2718(b)(1)(A), codified as amended at 42 U.S.C. 300gg-18).

56. Haberkorn, *supra* note 46; *see, e.g.*, NAT'L ASSOC. OF INS. COMM'RS, REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF THE MEDICAL LOSS RATIO FOR PLAN YEARS 2011, 2012, AND 2013 PER SECTION 2718(B) OF THE PUBLIC HEALTH SERVICE ACT § 8(F) (Oct. 27, 2010) [hereinafter NAIC REGULATION], *available at* http://naic.org/documents/committees_ex_mlr_reg_asadopted.pdf ("The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums *less Federal and State taxes* and licensing or regulatory fees." (emphasis added)).

57. Letter from Max Baucus et al., Chairmen, U.S. Congressional Comms., to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs. (Aug. 10, 2010), http://www.politico.com/static/PPM170_100811_taxes.html.

58. *See* Douglas Holtz-Eakin, *MLR Bait and Switch: PPACA's Latest Controversy*, AM. ACTION FORUM (Aug. 12, 2010), http://americanactionforum.org/content/mlr-bait-and-switch-ppacas-latest-controversy.

to promulgate MLR regulations,[59] sided with the NAIC by defining the MLR tax exclusion quite broadly in the regulations.[60]

3. Anti-Fraud Efforts

According to a conservative estimate of the National Health Care Anti-Fraud Association, "3% of all health care spending—or $68 billion [in 2007]—is lost to health care fraud."[61] During the MLR debate, insurance providers argued that money spent on anti-fraud measures should qualify as expenses for "activities that improve health care quality."[62] In other words, insurers want to put fraud prevention expenditures in the numerator of the MLR equation, making it easier to satisfy the minimum MLR requirement.

HHS disagreed, refusing to classify fraud-prevention activities as quality improvement measures except for "fraud detection/recovery expenses up to the amount recovered that reduces incurred claims."[63] Other "[e]xpenditures and activities that must not be included in quality improving activities" include cost containment activities, expenses related to running a claims adjudication system, retrospective and concurrent utilization review, and marketing expenses.[64]

By largely excluding anti-fraud expenses from the MLR numerator, HHS missed an opportunity to incentivize health insurance companies to adopt more advanced, effective fraud prevention measures.

59. *See* ACA § 10101(f), 124 Stat. at 886) ("The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties") (amending Public Health Service Act § 2718(b)(3), codified as amended at 42 U.S.C. 300gg-18).

60. MLR Regulations, *supra* note 35, 75 Fed. Reg. 74,864, 74,878 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) ("This interim final regulation adopts the NAIC recommendation that Federal income taxes on investment income and capital gains are not taxes based on premium revenues, and thus should not be used to adjust premium revenues, as specified in § 158.162, while all other Federal taxes allocated to health insurance coverage should be excluded from non-claims costs for purposes of the report required by section 2718. Section 158.162 also makes clear that Federal taxes which are excluded from non-claims costs are to be excluded from premium revenue when calculating an issuer's MLR.").

61. *The Problem of Health Care Fraud*, NAT'L HEALTH CARE ANTI-FRAUD ASS'N, http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud (last visited July 9, 2011)*; see also 2009 Financial Crimes Report*, FED. BUREAU OF INVESTIGATION, http://www.fbi.gov/stats-services/publications/financial-crimes-report-2009 (last visited July 9, 2011) ("[F]raudulent billings to health care programs, both public and private, are estimated between three and ten percent of total health care expenditures [$2.26 trillion per year].").

62. *See* Haberkorn, *supra* note 46.

63. MLR Regulations, *supra* note 35, 75 Fed. Reg. at 74,924–25.

64. *Id.*

A rational insurance company would likely spend more money to prevent fraud if such expenditures count toward the MLR. This would be a positive development, to the extent that ferreting out insurance fraud produces a net social benefit. Instead, the MLR regulations *discourage* health insurance providers from spending on fraud-prevention, because incurring such costs makes it more difficult for a provider to comply with the MLR mandate.

C. Current Events Surrounding the MLR

Passing the ACA did not end the MLR debate. States still have to decide whether to seek an exemption from the new federal MLR requirements, and Republican legislators continue to search for ways to undermine the ACA's MLR provisions.

1. State Requests for MLR Adjustments

As discussed above, sixteen states and the territory of Guam have asked HHS for MLR adjustments.[65] HHS recently approved or partially approved Maine's, New Hampshire's, Nevada's, Kentucky's, and Iowa's adjustment requests. It denied North Dakota's and Delaware's requests, and has not decided the remaining ten requests.[66] HHS clearly and concisely summarized the reasoning behind its decision to grant Maine's request as follows:

> The Maine Bureau of Insurance requested an adjustment of the 80 percent MLR to a 65 percent MLR standard. As of September 2010, nearly 37,000 Maine residents obtain health insurance coverage through Maine's individual health insurance market. One insurer, MEGA Life & Health Insurance Company, which covers more than a third of the market or approximately 14,000 Mainers, has said *it may exit the market if required to meet this higher standard in 2011 and 2012*. According to the State, since MEGA offers lower cost policies in Maine's individual market, if the insurer left the market, consumers may not be able to purchase new policies of comparable price and benefit design. For these reasons, HHS accepted the Maine Bureau of Insurance request for an adjustment to 65 percent for 2011 and 2012. HHS will allow the adjustment to continue through 2013, as Maine requested, if the State provides additional data at the end of 2012 to support a third year of the adjustment to 65 percent.[67]

65. *See supra* note 28 and accompanying text. The sixteen states are Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, Louisiana, Kansas, Delaware, Indiana, Michigan, Texas, Oklahoma, and North Carolina. *Id.*

66. *Id.*

67. *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance, The Maine MLR Adjustment*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, http://cciio.cms.gov/programs/

One can view this result either favorably or unfavorably, depending on one's point of view. ACA proponents will say that HHS's approval of Maine's request demonstrates that the safety valve works. The law contains sufficient safeguards to ensure that the new MLR requirements do not force insurers out of the market, potentially destabilizing it.

On the other hand, ACA opponents may claim that the Maine experience illustrates the perils of a national minimum MLR: insurance companies such as MEGA Life & Health would rather leave the market entirely than comply with the new MLR requirements. If enough insurers follow this course of action, the health insurance market, or at least a significant portion of it, will dry up, leaving consumers with limited options. HHS granted Maine's and other states' request for relief, but what about insurance providers in states that *do not* seek an MLR adjustment? Or what if HHS makes a mistake and denies a state's valid MLR adjustment request? If this occurs, the burdensome MLR regulations may drive good insurers out of the market in these states, reducing competition and consumer choice. Finally, consumer advocates who believe the MLR provisions do not go far enough in regulating insurance companies might complain that the MLR adjustment safety valve allows "junk insurance" providers, such as MEGA, to stay in business while continuing to gouge unsuspecting customers.[68]

The other states that requested MLR adjustments had concerns paralleling those expressed by Maine. Namely, these states worried that the new 80% MLR requirement in the individual market will cause insurance providers to exit the health insurance market, which in turn will undermine the integrity of the market. For example, New Hampshire stressed that a single insurance carrier dominates the individual insurance market in the state, and smaller carriers may not participate at all if they must comply with the federal MLR requirement.[69] Nevada noted that as of September 1, 2010, three out of twenty-eight

marketreforms/mlr/medical_loss_ratio_maine.html (last visited Apr. 13, 2011) [hereinafter *The Maine MLR Adjustment*] (emphasis added).

68. *See* Drew Armstrong, *Maine Wins First Waiver to Health Insurance Premium Rules*, BLOOMBERG (Mar. 8, 2011), http://www.bloomberg.com/news/2011-03-08/maine-wins-first-waiver-to-health-insurance-premium-rules.html ("The city of Los Angeles sued . . . MegaLife . . . on Oct. 20 for allegedly selling 'junk insurance' with obscure provisions that left customers 'without coverage when they needed it most,' according to court documents.").

69. Letter from Robert A. Sevigny, Comm'r N.H. Ins. Dep't, to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs., at. 1 (Jan. 6, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/newhampshire/mlr_adj_req_01062010.pdf.

carriers "have imposed moratoriums on new business while they determine their ultimate market strategy" and may exit the market "unless there is some relief granted through an adjustment to the medical loss ratio standard."[70] Similarly, Florida contended that implementing the ACA's new MLR standards will cause insurance companies to "exit the individual market or cease issuing new policies," "erect barriers to entry into the individual market," "reduce consumer choice," and "severely hamper agent involvement in the individual market to the severe detriment of Florida consumers."[71] The HHS's decisions regarding the remaining MLR adjustment applications in the coming months will shed more light on the current debate surrounding this controversial issue.

2. Republican Party's Efforts to Undermine the MLR

The Republican Party failed to keep the ACA from becoming law, but that has not stopped a number of Republican legislators from continuing to battle against the ACA's MLR mandate. For example, on February 18, 2011, Republican Congressman Tom Price (Georgia) introduced an amendment to the Full Year Continuing Appropriations Act of 2011, so that "[n]one of the funds . . . may be used by the [HSS] to implement or enforce section 2718 of the Public Health Service Act [the ACA's MLR provision]."[72] Presumably, Congressman Price proposed this amendment to stifle federal government efforts to administer the new federal MLR regime.

On March 9, 2011, in another attack on the MLR provision, Republican Congressman Carter (Texas) discussed the HHS MLR regulation and then noted: "We actually have a bill that is coming before this Congress . . . . It mandates that all new major rules must be approved by Congress before becoming law."[73] This statement not-so-subtly implies that at least some ACA opponents will go to great lengths to prevent the MLR regulations from taking effect, including authorizing Congress to take a second look at the HHS regulations before they become law. Whether critics will successfully derail the MLR laws and/or regulations remains to be seen.

70. Letter from Brett J. Barratt, Nev. Comm'r Ins., to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs., at. 3 (Feb. 9, 2011) (citations omitted), http://cciio.cms.gov/programs/marketreforms/mlr/states/nevada/mlr_letter_to_sec_sebelius_2_9_11.pdf.

71. Letter from Kevin M. McCarty, Comm'r, Fla. Office of Ins. Reg., to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs., at. 2 (Mar. 11, 2011) http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/petition_mlr_03112011_ltr_to_hhs.pdf.

72. 157 CONG. REC. H1261 (daily ed. Feb. 18, 2011) (statement of Rep. Tom Price).

73. 157 CONG. REC. H1651 (daily ed. Mar. 9, 2011) (statement of Rep. John Carter).

3. The Rhetoric Continues

Congressional representatives on both sides of the aisle have ramped-up the rhetoric in the MLR debate. For instance, on February 18, 2011, Representative Price introduced an amendment to the Full Year Continuing Appropriations Act that would impede funding of the MLR initiative.[74] In justifying his proposal, Representative Price excoriated the MLR mandate as extreme government intervention into private industry:

> Last year, this Congress made a lot of decisions that gave Washington control over our health care system. And a perfect example of that control is that ObamaCare mandates to the companies that provide the health coverage for individuals, helping individuals, how to run their business. Essentially, the Federal Government is in the business of dictating to private companies what they should do to run their business, what kind of coverage they can provide, what kind of prices they can charge, what kind of definition of quality care, and what meets the definition of essential services for individuals. It really is central planning at its finest, and it is certainly not the government's role in a free market system.[75]

Similarly, on March 9, 2011, Representative Carter spoke about the MLR as the designee of the majority leader during debate over the Congressional Review Act.[76] Representative Carter worried that the new MLR mandate would cause many individuals to lose their health insurance entirely:

> This [MLR] regulation requires all health plans to pay a minimum of 80 percent of premiums toward health services. Larger insurers should pay a minimum of 85 percent. Industry analysis estimates that as many as 47 percent of the participants in individual and small group plans which have higher administrative costs due to economies of scale will lose their health insurance if this regulation becomes law. So this one regulation, which comes out of what we call the ObamaCare bill, could cause 47 percent of the people who have small to midsize health care plans to lose their health care plan.[77]

Democrats responded, suggesting that those who oppose the MLR mandate are filling the pockets of insurance company executives. For example, Frank Pallone, a Democratic Congressman from New Jersey, stated:

74. 157 CONG. REC. H1261 (daily ed. Feb. 18, 2011) (statement of Rep. Tom Price).

75. *Id.*

76. 157 CONG. REC. H1649–H1653 (daily ed. Mar. 9, 2011) (statement of Rep. John Carter).

77. *Id.* at H1651.

> If you're with the gentleman from Georgia [Price], you are on the side of the big insurance companies, and you'll want to make sure that they make bigger profits, that they get bigger bonuses, that they pass out bigger dividends and more money to their CEOs . . . . That's what this is all about. You're going to hand back to the insurance companies control over what happens with the money that you paid in your premium so they can do whatever they want with it and make whatever profit they want. I think it's wrong.[78]

According to Republicans, "ObamaCare's"[79] MLR regulation could cause *half of the entire small group insurance market to disappear.*[80] According to Democrats, opposing the MLR requirement equates to *favoring greedy insurance company executives.*[81] This kind of fear-mongering and name-calling adds no value to the legitimate debate regarding the difficult and important issues at hand: whether or not the MLR law is both constitutional and sound policy.

II. The Constitutionality of the ACA's MLR Provisions

Prolific legal scholar Richard Epstein has argued that the ACA's MLR provisions may be unconstitutional.[82] Although Epstein voiced his concerns in December of 2009 in relation to an earlier, in-progress version of the ACA,[83] the basic structure of his constitutional analysis applies to the version of the ACA that ultimately became law in March of 2010. This Part attempts to flesh-out Professor Epstein's position, in part by examining and synthesizing several cases in which courts have found unconstitutional government ratemaking. This Part concludes that the ACA's MLR provisions are likely unconstitutional.

78. 157 CONG. REC. H1262 (daily ed. Feb. 18, 2011) (statement of Rep. Frank Pallone, Jr.).

79. "ObamaCare" is a slang term used by some when referring to the ACA. Many consider the term derogatory. *E.g.*, Liz White, *Stewart Calls It: 'Obamacare' Derogatory*, NEWSWEEK (Apr. 21, 2010), http://www.newsweek.com/blogs/the-gaggle/2010/04/21/stewart-calls-it-obamacare-derogatory.html.

80. *See supra* text accompanying note 77.

81. *See supra* text accompanying note 78.

82. *See* Epstein, *supra* note 2 (arguing that the MLR provision would "would convert private health insurance companies into virtual public utilities" because it "systematically strips the regulated health-insurance issuers of their constitutional entitlement to earn a reasonable rate of return . . . .").

83. *Id.* at 1 n.1.

A. The Constitutional Concern in Brief

Epstein bases his challenge to the ACA's minimum MLR requirement in the Constitution's Takings and Due Process Clauses.[84] First, Epstein analogizes the MLR requirement to government ratemaking.[85] Under the circumstances, this is a logical first step. Before the ACA, the federal government traditionally shied away from regulating the health insurance industry, and the Supreme Court has never addressed the MLR issue directly.[86] Government ratemaking, a generic term for government-set rates in various industries, is the closest analogy. Using the Supreme Court's ratemaking cases for support, Epstein derives the following principle: "A basic constitutional requirement is that any firm in a regulated market be allowed to recover a *risk-adjusted competitive rate of return* on its accumulated capital investment."[87] Put differently, the higher the risk, the greater the constitutionally-required rate of return.[88]

Epstein then makes another assumption: "[T]hat the health insurance industry is competitive or could easily be made competitive."[89] Because the industry is competitive,[90] the prevailing market rates (including the MLR) necessarily reflect the "risk-adjusted competitive rate of return" required by the Constitution.[91] It follows that any law mandating an MLR above that already prevailing in the competitive health insurance marketplace violates the Constitution.[92] The ACA does just that and is therefore unconstitutional. In Epstein's words:

84. *Id.* at 20.

85. *See id.* at 3 ("These constitutional provisions have been subject to extensive interpretation in the Supreme Court in ratemaking cases, which must be taken into account in dealing with the legislation.").

86. *See* Mila Kofman & Karen Pollitz, HEALTH POLICY INST. GEORGETOWN UNIV., HEALTH INSURANCE REGULATION BY STATES AND THE FEDERAL GOVERNMENT: A REVIEW OF CURRENT APPROACHES AND PROPOSALS FOR CHANGE 1 (Apr. 2006), *available at* http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf ("The federal government has historically respected the state's role in regulating insurance" and "States remain the primary regulators of insurance companies and insurance products.").

87. *Id.* at 3 (citing Duquesne Light Co. v. Barasch, 488 U.S. 299 (1988)) (emphasis added).

88. *Id.* at 20 (citing Smyth v. Ames, 169 U.S. 466 (1899)).

89. *Id.* at 21.

90. *See id.* at 23 (indicating that "[t]he unregulated rates are already at the competitive level").

91. *See id.* at 21 ("Once it is clear—and it is generally clear—that the health insurance industry is competitive or could easily be made competitive, the entire rationale for government ratemaking is undermined.").

92. *See infra* text accompanying note 93.

> [I]t is impossible for the rate regulation of firms in the competitive health insurance industry to recover the constitutionally permissible rate of return. So long as competitive rates of return remain the constitutional benchmark, rate regulation necessarily fails. The unregulated rates are already at the competitive level. Any system that reduces revenues, raises costs, and increases uncertainty cannot possibly meet the applicable constitutional standard.[93]

Despite Epstein's generally sound argument against the MLR's constitutionality, several particular aspects of his reasoning are troublesome. First, the current health insurance market is not truly "competitive." For one thing, the market is extremely concentrated. According to a 2009 report, one single carrier controls more than half the market in twenty-one states, and two carriers control more than half the market in thirty-nine states.[94] HHS granted Maine's request for an MLR adjustment primarily because one insurance carrier that controlled over 30% of the individual market threatened to leave.[95] Additionally, the cost of health insurance continues to skyrocket. In 2011, "groups of more than 20 workers have been experiencing premium increases of around 20 percent . . . while smaller groups are seeing increases of 40 percent to 60 percent or more."[96] Although not dispositive, market concentration and rising prices indicate that the health insurance market is less than optimally competitive.

However, once the ACA's health insurance exchanges take root, the market *should be* competitive. Indeed, exchanges are "intended to create a more organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them."[97] Therefore, although Epstein's assumption of competitiveness is not currently accurate, it will be soon once the ACA's health insurance exchanges are implemented. As such, Epstein's assumption of competitiveness does not doom his constitutional analysis of the ACA's MLR mandate.

93. Epstein, *supra* note 2, at 23.

94. Ben Furnas & Rebecca Buckwalter-Poza, *Health Care Competition: Insurance Market Domination Leads to Fewer Choices*, CTR. FOR AM. PROGRESS (June 2009), http://www.americanprogress.org/issues/2009/06/pdf/health_competitiveness.pdf.

95. *The Maine MLR Adjustment*, *supra* note 67.

96. Robert Pear, *Health Care Premiums Soar as Coverage Shrinks*, N.Y. TIMES, Mar. 4, 2011, at A13.

97. *Explaining Health Care Reform: What Are Health Insurance Exchanges*, KAISER FAMILY FOUND. (May 2009), http://www.kff.org/healthreform/upload/7908.pdf.

Second, under Epstein's reasoning, the Constitution would foreclose *any rate regulation* in the health insurance industry.[98] Epstein believes that "the entire rationale for government ratemaking is undermined [when the health insurance market is competitive]. The point of ratemaking was to require the firm to accept competitive rates of returns in a market setting where it enjoyed monopoly power."[99] But the Constitution does not go this far. Although government rate setting in a competitive market may be unnecessary and unwise,[100] such government intervention is constitutional unless the government sets a rate so low as to be "confiscatory"[101] or "unreasonable."[102]

Third, Epstein's reliance on the public utility analogy contains an internal inconsistency. On the one hand, he cites public utilities cases such as *Duquesne Light Co. v. Barasch*[103] to show that the government must give firms in regulated markets an opportunity to earn a "risk-adjusted competitive rate of return."[104] On the other hand, he asserts that government rate setting only makes sense in the context of monopolies such as public utilities, not in competitive markets, such as the health insurance industry.[105] If public utilities (monopolies) fundamentally differ from the health insurance industry (competitive) in the rate regulation context, then relying on public utilities cases such as *Duquesne Light* to craft a constitutional rule governing the health insurance industry does not make much sense.

Most importantly, Epstein does not provide guidance on what constitutes a risk-adjusted competitive rate of return. The government may exercise significant control over the health insurance industry be-

98. *See* Epstein, *supra* note 2, at 21.

99. *Id.*

100. The vast majority of economists believe that profit caps and government price controls reduce quality and distort the allocation of resources. Hugh Rockoff, *Price Controls*, *in* THE CONCISE ENCYCLOPEDIA OF ECONOMICS 409, 409 (David R. Henderson ed., 2008).

101. *See, e.g.*, Aetna Ins. Co. v. Hyde, 275 U.S. 440, 447 (1928) (indicating that the Supreme Court would declare a rate as confiscatory if "the facts relied on to restrain the enforcement of rates prescribed under the sanction of state law [are] specifically set forth, and from them it . . . clearly appear that the rates would necessarily deny to the plaintiff just compensation and deprive it of its property without due process of law").

102. *See, e.g.*, KN Energy, Inc. v. Cities of Broken Bow, 505 N.W.2d 102, 107 (Neb. 1993) ("[I]n setting rates that may be charged by a utility, a state cannot set rates which are unjust, *unreasonable*, and confiscatory and which, therefore, deprive the utility of property without the due process of law guaranteed by U.S. Const. amend. XIV . . . ." (emphasis added)).

103. 488 U.S. 299 (1988).

104. Epstein, *supra* note 2, at 3.

105. *Id.* at 21.

cause healthcare is a vital public interest.[106] Because the government possesses broad power to supervise the insurance industry and has a legitimate interest in regulating rates,[107] "insurance companies have no constitutional right to be regulated under 'open competition' laws."[108] However, as mentioned above,[109] the government still cannot impose confiscatory or unreasonable rates on insurance providers. This begs the question: how do the courts distinguish between permissible rate regulation (here, a permissible MLR law) and an unconstitutional confiscatory MLR requirement? Because the courts have not provided clear guidelines, this question remains unresolved.

B. Constitutional vs. Confiscatory

The words unreasonable and confiscatory mean nothing without context. Therefore, courts have developed a number of principles to analyze whether or not a government-set rate is unreasonable or confiscatory, and therefore unconstitutional.

First, in the ratemaking context, the Constitution does not require the government "to fix rates which will guarantee a profit to all insurers," but at the same time, the government cannot "constitutionally fix rates which are so low that if the insurers engage in business they may do so only at a loss."[110] In the MLR context, this means that the government must set the minimum MLR at a level that gives insurers the *opportunity to make a fair profit*. As Professor Epstein suggests, a "fair profit" should account for the level of risk involved in the business.[111] Rates that merely protect insurers from insolvency[112] or per-

106. *See* Golden Rule Ins. Co. v. Ins. Dep't., 641 A.2d 1255, 1260 (Pa. Commw. Ct. 1994) ("Our Supreme Court has held that the Commonwealth may regulate the business of insurance, because it is a business affected with a public concern."); Smith v. Dep't of Ins., 507 So.2d 1080, 1092–93 (Fla. 1987) ("We find a legitimate state interest in regulating these insurance rates, and hold these insurance companies have no constitutional right to be regulated and governed by this specific type of 'open competition' law.").

107. *See, e.g.*, O'Gorman & Young, Inc. v. Hartford Fire Ins. Co., 282 U.S. 251, 257 (1931) ("The business of insurance is so far affected with a public interest that the State may regulate the rates.").

108. 16B C.J.S. *Constitutional Law* § 1319 (2007) (citing Reed v. Farmers Ins. Grp., N.E. 2d 1052 (1999)).

109. *See* cases cited *supra* notes 101–02.

110. Aetna Cas. & Sur. Co. v. Comm'r of Ins., 263 N.E.2d 698, 703 (Mass. 1970).

111. *See* Epstein, *supra* note 2, at 20–21 (criticizing the Reid Bill because it had no "single provision that looks to ensuring a minimum [risk-adjusted] rate of return."); *see also* Fed. Power Comm'n v. Hope Natural Gas Co., 320 U.S. 591, 605 (1944) ("Rates which enable the company to operate successfully, to maintain its financial integrity, to attract capital, and to *compensate its investors for the risks assumed* certainly cannot be condemned as invalid, even though they might produce only a meager return on the so-called 'fair value' rate base." (emphasis added)).

mit insurers to break even[113] do not pass constitutional muster.[114] Of course, neither the government nor anyone else can guarantee that all insurers *will* make a profit under a particular regulatory scheme.

Second, courts stress that the government should give insurers the *opportunity to oppose a rate change*.[115] In other words, courts are more likely to find government rate regulation constitutional when the regulatory mechanism includes a safety valve for insurance companies. In *Keystone Insurance Co. v. Foster*, the Eastern District of Pennsylvania rejected a constitutional challenge to a law setting insurance rates.[116] In reaching its decision, the court stressed that the law contained a "constitutional 'safety valve,'" permitting the insurance commissioner to grant rate relief to an insurance company experiencing "extraordinary circumstances," thereby avoiding "a confiscatory impact on an insurance company."[117]

Similarly, in *Calfarm Insurance Co. v. Deukmejian*, the California Supreme Court considered the constitutionality of an insurance rate-setting statute.[118] After severing an unconstitutional provision from the law, the court held that "the remaining regulatory provisions should afford insurers an effective means of relief from any confiscatory rate."[119] One safety valve in *Calfarm* included statutory language prohibiting the insurance commissioner from approving or permitting "any rate 'which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter'—language which makes it

112. Geeslin v. State Farm Lloyds, 255 S.W.3d 786, 794–95 (Tex. App. 2008) ("We note, however, that rates can be confiscatory without necessarily leading to insolvency. Thus, the proof provision set out in [the statute], by allowing for the imposition of confiscatory rates, fails to provide regulated companies with a constitutionally adequate review of government-set rates. We therefore hold that the proof provision is unconstitutional on its face.").

113. Guar. Nat. Ins. Co. v. Gates, 916 F.2d 508, 515–16 (9th Cir. 1990) ("We agree that [the statute is unconstitutional because it provides no] mechanism to guarantee a constitutionally required fair and reasonable return . . . . It follows from this definition that if projected losses and expenses are simply met, the rates are adequate. Thus, [the statute] guarantees only that an insurer will break even; it does not guarantee the constitutionally required 'fair and reasonable return.'").

114. *See* cases cited *supra* notes 112–13. Note the different standards used by the Texas Court of Appeals (insolvency) and the Ninth Circuit (breaking even). This inconsistency can be explained by the lack of clear Supreme Court guidance on how to properly define the constitutionally required rate of return.

115. *See* U.S. Healthcare, Inc. v. Curiale, 615 N.Y.S.2d 239, 242 (1994) (holding that the regulatory authority's determination establishing a lower rate was arbitrary and capricious because the insurer had no opportunity to oppose this rate reduction).

116. Keystone Ins. Co. v. Foster, 732 F. Supp. 36, 38–39 (E.D. Pa. 1990).

117. *Id.*

118. Calfarm Ins. Co. v. Deukmejian, 771 P.2d 1247, 1249 (Cal. 1989).

119. *Id.* at 1251.

clear that the commissioner can grant relief from confiscatory rates."[120] A second safety valve allowed aggrieved insurers to apply for rate relief.[121] As discussed in Part I.A., the ACA's MLR provisions do contain a safety valve, namely the opportunity for states to request an adjustment to the federal MLR standards. The question then becomes whether this particular safety valve sufficiently protects health insurers nationwide from unreasonable rates.[122]

Third, an insurance company challenging a rate as confiscatory bears a *heavy burden of proof*,[123] and *courts should generally defer* to the rate setting authority.[124] Specifically, a "court cannot usurp the function of administrative officials . . . or substitute its own judgment for that of the officials . . . and must give deference to their determinations."[125] Of course, a court must still reject a government rate determination that involves a violation of constitutional rights.[126] Regarding the burden of proof in rate setting cases, a "party challenging a rate as being confiscatory has the burden of proving that it has been *deprived of the opportunity to earn a fair return* and that its failure to earn a sufficient return is *directly attributable to the inaccuracy of the rate*."[127] Therefore, an insurance company opposing the ACA's MLR provisions must show that the new minimum MLR (80% in the small group and individual markets and 85% in the large group market) eliminates the company's ability to make a fair profit.

Fourth, the government must consider the *actual and predicted financial and economic landscape of the marketplace* when setting rates, which is a *fact-intensive* inquiry.[128] As eloquently stated in the *Corpus Juris Secundum* encyclopedia of American law:

120. *Id.* at 1253.

121. *Id.* at 1251.

122. *See infra* Part II.C.1 for a discussion of the flaws in the MLR safety valve provision.

123. Aetna Ins. Co. v. Hyde, 275 U.S. 440, 447–48 (1928) ("Jurisdiction of this court to set aside state-made rates as confiscatory will be exercised only in clear cases; and the burden is on one seeking that relief to bring forward and satisfactorily prove the invalidating facts.").

124. 44 C.J.S. *Insurance* § 120 (2007).

125. *Id.* (citations omitted).

126. *Id.*

127. *Id.* (emphasis added).

128. *See* 64 Am. Jur. 2d *Public Utilities* § 133 (2011) ("In determining fair rates, the regulatory body considers a representative level of anticipated revenues and expenses and the property employed by the utility to provide service to its customers. The amount that a utility is permitted to recover from its customers in the rates it charges is determined by its revenue requirement . . . . The setting of utility rates requires a certain amount of prediction concerning a utility's future revenue requirement." (citations omitted)).

> [W]hat constitutes a reasonable rate of return is primarily a question of fact, and there is no immutable standard for its measurement . . . The rate *cannot be based merely on policy*, but must be determined from the evidence, and, accordingly, *depends largely on the facts and circumstances* of the particular case.[129]

As discussed in detail below, Congress made no effort to evaluate the realities of the insurance market when setting the MLR at 80% in the individual and small groups markets and 85% in the large group market.[130] It was a purely political decision. This alone renders the ACA's MLR provision constitutionally suspect.

In accordance with the preceding guidelines and despite judicial deference to rate-setting authorities, courts will strike down insurance regulations when the government goes too far by setting unreasonable, confiscatory rates. In *Geeslin v. State Farm Lloyds*,[131] the Texas Court of Appeals struck down the proof provision of a rate-setting statute as unconstitutional on its face.[132] The provision in question required "the commissioner to approve potentially confiscatory rates, absent clear and convincing evidence that such rates would lead to insolvency."[133] The court reasoned that "rates can be confiscatory without necessarily leading to insolvency," so the provision failed "to provide regulated companies with a constitutionally adequate review of government-set rates."[134]

The Ninth Circuit reached a similar result in *Guaranty National Insurance Co. v. Gates*.[135] In *Gates*, the court interpreted the Nevada Insurance Code to guarantee "only that an insurer will break even."[136] The *Gates* court then held the law unconstitutional because a "break even" provision does not "guarantee the constitutionally required 'fair and reasonable return.'"[137]

In *Aetna Casualty & Surety Co. v. Commissioner of Insurance*,[138] the Massachusetts Supreme Court considered the constitutionality of a law setting rates in the automobile insurance industry.[139] In doing so, the court flatly rejected the government's argument that it had unfet-

129. 73B C.J.S. *Public Utilities* § 76 (2004) (emphasis added) (citations omitted).

130. *See infra* Part II.C.2 for a discussion of Congress's decision-making process in setting MLR benchmarks.

131. 255 S.W.3d 786 (Tex. App. 2008).

132. *Id.* at 794–95.

133. *Id.* at 795.

134. *Id.*

135. 916 F.2d 508, 515–16 (9th Cir. 1990).

136. *Id.* at 515.

137. *Id.*

138. 263 N.E.2d 698 (Mass. 1970).

139. *Id.* at 699.

tered discretion to set insurance rates and "if the companies cannot write the insurance at those rates they are free to stop writing it."[140] Insurers "are not required to either submit to confiscatory rates or go out of business," according to the court.[141] The court concluded that the law in question set confiscatory rates and therefore violated the Constitution.[142]

Finally, in *Calfarm Insurance Co. v. Deukmejian*,[143] the California Supreme Court confronted a rate-setting law "which provides that the commissioner cannot approve a rate increase . . . unless the insurer is substantially threatened with insolvency."[144] The court held this "insolvency only" provision unconstitutional because it did not "afford insurers an effective means of relief from any confiscatory rate."[145] However, the court saved the rest of the statute by severing the unconstitutional provision.[146]

The preceding discussion illustrates two important points. First, courts, including the Supreme Court, have not delineated a clear boundary between constitutional and confiscatory rates. Second, despite this ambiguity, courts will strike down government set rates when the government goes too far.

C. Applying Constitutional Principles to the ACA's MLR Provision

Given the constitutional limitations of government rate regulation in the insurance industry, how will courts view the ACA's MLR mandate? This Part argues that the MLR's safety valve contains fundamental flaws, and Congress used an unacceptable process to select the benchmark MLRs. But while the ACA's MLR provision could conceivably fall under a facial constitutional attack, the fact that many insurance companies profit while maintaining MLRs above the ACA's 80% or 85% thresholds suggests that a facial challenge will likely fail. On the other hand, if a particular insurance company can show that the 80% or 85% MLR requirement would force the company to exit the market or does not permit the company to earn a reasonable, nonconfiscatory rate of return, the company's as-applied constitutional challenge would almost certainly succeed.

140. *Id.* at 703.
141. *Id.*
142. *Id.*
143. 771 P.2d 1247 (Cal. 1989).
144. *Id.* at 1251.
145. *Id.*
146. *Id.*

1. Flaws in the MLR's Safety Valve

As discussed in Part I.A., the ACA gives HHS discretion to adjust the MLR benchmark rates in two situations: (1) in the small group and individual markets of a state, if the Secretary determines that the 80% MLR "may destabilize the individual market in such State,"[147] and (2) "if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges."[148] These provisions are "safety valves" because they provide escape routes from the ACA's otherwise mandatory 80% or 85% MLR requirement. But unfortunately, these particular safety valves do not adequately protect health insurance companies from confiscatory rates.

First, the ACA's implementing regulation permits *only the states, not the insurance providers*, to request an adjustment to the MLR.[149] If a state does not request an adjustment, the health insurance providers in the state have no recourse from a confiscatory MLR. This stands in stark contrast to the safety valves that courts have credited in cases such as *Calfarm Insurance Co. v. Deukmejian* and *Keystone Insurance Co. v. Foster*, in which the insurance companies, not the states, had the power to seek relief from unreasonable rates.[150]

Second, the ACA's safety valves do not guarantee a non-confiscatory rate of return. Specifically, "[i]n order to qualify for this [MLR] adjustment, a State must demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a *likelihood of destabilizing the individual market* and could result in fewer choices for consumers."[151] In *Geeslin v. State Farm Lloyds*, the Texas Court of Appeals held an insurance rate regulation unconstitutional, in part because it

147. ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 886 (2010) (amending Public Health Service Act § 2718(b)(1)(A)(ii), codified as amended at 42 U.S.C. 300gg-18).

148. *Id.* at 887 (amending Public Health Service Act § 2718(d), codified as amended at 42 U.S.C. 300gg-18).

149. *See Medical Loss Ratio: Getting Your Money's Worth*, HEALTHCARE.GOV (Nov. 22 2010), http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html [hereinafter *Getting Your Money's Worth*] ("Consistent with NAIC recommendations, the regulation establishes a process for *States to request such an adjustment* for up to three years – an effective State-based transition. In order to qualify for this adjustment, a *State must demonstrate* that requiring insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers." (emphasis added)).

150. *See Calfarm*, 771 P.2d at 1251 (noting that the law allows insurers to seek rate relief); Keystone Ins. Co. v. Foster, 732 F. Supp. 36, 38 (E.D. Pa. 1990) (noting that the law permits the commissioner to grant relief to insurance companies).

151. *Getting Your Money's Worth*, *supra* note 149 (emphasis added).

merely protected companies from insolvency, and "rates can be confiscatory without necessarily leading to insolvency."[152] Analogously, rates can be confiscatory without leading to market destabilization. For example, consider a market with ten health insurance providers. If the ACA's MLR provisions force four of those insurers to exit the market because they can no longer earn a reasonable rate of return, the rate is confiscatory. However, the MLR has not necessarily destabilized the market so long as the remaining six insurers can absorb the four now-defunct insurers' prior clients. Thus, the ACA's MLR adjustment provision does not afford health insurance companies the constitutionally-required level of protection from confiscatory rates.

Third, the ACA's safety valves apply only to the individual and/or small group markets, not to the large group market.[153] Therefore, insurance providers in the large group market lack protection from confiscatory rates. In other words, if a large group insurance provider cannot raise its MLR above 85%, as required by the ACA, the provider must either operate at a loss or exit the large group insurance business. Forcing an insurance company to make this choice is unconstitutional.[154]

Finally, the ACA's MLR adjustment safety valve is only temporary. Specifically, "the regulation establishes a process for States to request such an adjustment *for up to three years*."[155] After this three-year transition period, presumably states will no longer be allowed to request an adjustment to the MLR. Therefore, even if the safety valve is constitutional right now, which is doubtful for the reasons set forth above, it will certainly become unconstitutional several years down the line.

2. Congress's Questionable Decision-Making Process

Congress' true motivation for setting the MLR threshold at 80% and 85% is suspect. As detailed in Part II.B., the government must consider the economic and financial realities of the insurance market

152. Geeslin v. State Farm Lloyds, 255 S.W.3d 786, 794–95 (Tex. App. 2008).

153. *See* ACA § 10101(f), 124 Stat. at 886 (permitting the SHHS to adjust the MLR in the small group and individual markets if an 80% MLR would destabilize the individual market) (amending Public Health Service Act § 2718(b)(1)(A)(ii), codified as amended at 42 U.S.C. 300gg-18); *id.* at 887 (allowing the SHHS to adjust the MLR if the establishment of health insurance exchanges undesirably increase the volatility in the individual market).

154. *See* Aetna Cas. & Sur. Co. v. Comm'r of Ins., 263 N.E.2d 698, 701–04 (Mass. 1970) ("[The government] may not constitutionally fix rates which are so low that if the insurers engage in business they may do so only at a loss. The insurers are *not required to either submit to confiscatory rates or go out of business*." (emphasis added)).

155. *Getting Your Money's Worth*, *supra* note 149 (emphasis added).

when setting rates. "The rate *cannot be based merely on policy*, [but instead, it] must be determined from the evidence like any other fact."[156] Thus, the rate "*depends largely on the facts and circumstances* of the particular case."[157]

On December 13, 2009, several months before the enactment of the ACA and during the heat of the healthcare reform debate, the Congressional Budget Office ("CBO") released a memo discussing the ACA's MLR proposal.[158] The memo stated that if Congress set MLRs higher than 80% for the individual and small-group markets or 85% for the large-group market, the CBO would record transactions in those markets as "cash flows in the federal budget."[159] According to Megan McArdle, business and economics editor of *The Atlantic*, "[n]eedless to say, it is very doubtful that Congress wishes to consolidate the operations of the nation's health insurers on the financial statements of the United States government."[160] In other words, Congress does not want to add fuel to the already-contentious yearly budget debates by including private health insurance company balance sheets on the government books.

Not surprisingly, Congress latched on to the 80% and 85% MLR numbers from the CBO memo, passing a bill with the highest possible MLRs that do not trigger CBO's threat. In fact, the language and structure of the ACA itself suggest that Congress harbored doubts about the appropriate MLR until the very last minute. Section 1001 of the ACA would have set the MLR thresholds at 75% in the individual market and 80% in the group market, a less stringent requirement than the ultimately enacted 80% and 85% regime.[161] However, section 10101(f) of the ACA amended the just-added section 1001 to raise the MLR requirements to 80% in the small group and individual markets and 85% in the large group market.[162]

156. Pittsburg v. Pa. Pub. Utils. Comm'n, 69 A.2d 844, 850 (1949) (emphasis added).

157. 73B C.J.S. *Public Utilities* § 76 (2004) (emphasis added) (citations omitted).

158. *Budgetary Treatment of Proposals to Regulate Medical Loss Ratios*, CONG. BUDGET OFFICE, (Dec. 13, 2009), https://www.cbo.gov/ftpdocs/107xx/doc10731/MLR_and_budgetary_treatment.pdf [hereinafter *Budgetary Treatment*].

159. *Id.*

160. Megan McArdle, *The CBO Warns on Too-High Medical Loss Ratio Requirements*, THE ATLANTIC (Dec. 15, 2009), http://www.theatlantic.com/business/archive/2009/12/the-cbo-warns-on-too-high-medical-loss-ratio-requirements/31863/.

161. ACA, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 137 (2010) (amending the Public Health Service Act to add in part § 2718(b)(1)(A)–(B), codified as amended at 42 U.S.C. 300gg-18).

162. *Id.* § 10101(f), 124 Stat. at 885 (amending Public Health Service Act § 2718(b)(1)(A), codified as amended at 42 U.S.C. 300gg-18).

Congress' decision to set the MLR at 80% and 85% was *not* based on economic analysis of the insurance market, balancing the interests of insurance companies and consumers, or what MLR will yield a reasonable, non-confiscatory rate of return for the insurance industry, but *politics*. This cannot be stressed enough. Congress did not want the health insurance industry's financials on government books, and it set the MLR accordingly. This decision-making process falls far short of the fact-intensive, market-specific, economic-based analysis required by the Constitution when the government sets rates.

3. The Fate of a Constitutional Challenge to the MLR

In spite of all of the defects in the ACA's MLR provision, it might withstand a facial constitutional challenge because some insurance companies can, and do, make a reasonable profit while maintaining MLRs within the range required by the statute. In other words, some will argue that as applied to the insurance industry as a whole, the ACA's MLR provisions do not impose confiscatory rates.

To succeed on a facial challenge, the petitioner must show that the legislation under attack is unconstitutional in all circumstances.[163] Accordingly, an insurance company facially challenging the ACA's MLR requirement would probably have to show that *no insurance company* could earn a reasonable profit while maintaining an MLR of at least 80% in the small group and individual markets and 85% in the large group market. However, many insurance companies already operate profitably at or above the newly-mandated MLRs. For instance, on April 15, 2010, the U.S. Senate Committee on Commerce, Science, and Transportation reported that, in 2009, the largest health insurance providers displayed MLR ratios ranging from 68.1% to 88.1% in the individual market, 78.2% to 92.1% in the small group market, and 83.3% to 88.2% in the large group market.[164] A recent article also mentions that most of Kansas's top health insurers already meet the MLR requirement.[165] Because some health insurance companies can

163. *See* United States v. Salerno, 481 U.S. 739, 745 (1987) ("A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid.").

164. STAFF OF SENATE COMM. ON COMMERCE, SCI., & TRANSP., 111TH CONG., IMPLEMENTING HEALTH INSURANCE REFORM: NEW MEDICAL LOSS RATIO INFORMATION FOR POLICYMAKERS AND CONSUMERS 3 tbl.I (2010), *available at* http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667.

165. Dave Ranney, *State's Top Health Insurers Meet Medical-Loss Ratio Requirement*, KAN. HEALTH INST. (Mar. 4, 2011), http://www.khi.org/news/2011/mar/04/most-insurers-meet-medical-loss-ratio-requirement/.

make money under the ACA's 80% and 85% MLR regime, a court would probably reject a facial challenge to the Act's MLR provisions.

However, if an individual insurance company demonstrates that the federal MLR requirement would either force the company to exit the market or prevent the company from earning a reasonable profit, the company's as-applied constitutional challenge would likely prevail. In analyzing the issue, a court would certainly consider the limitations of the MLR safety valve provisions and the suspicious manner in which Congress chose the 80% and 85% MLR thresholds as factors cutting against the constitutionality of the Act. In fact, a court may believe that the ACA's MLR safety valve provisions cannot adequately protect *any* health insurance company from the threat of confiscatory rates, even if *some* companies can make a profit under the ACA's MLR requirements. Because of Congress' questionable motives for setting the specific MLR benchmarks, such a court would likely follow the Texas Court of Appeals' analysis in *Geeslin v. State Farm Lloyds* and hold the ACA's MLR provision unconstitutional on its face for failing to sufficiently protect the industry against unreasonable rates.[166]

Some might argue that states have been imposing MLR requirements on insurance companies for years, so why cannot the federal government do the same? First, while it is true that the federal government does not necessarily violate the Constitution by setting a minimum MLR in the health insurance industry, the ACA's particular MLR provision presents constitutional problems for all the reasons discussed above.[167] Second, a governmental entity that sets confiscatory rates violates the Constitution, regardless of whether the rate-setting entity is federal or state. The Supreme Court has never immunized the federal government in the rate setting context. As detailed above, courts will not hesitate to strike down insurance rate laws that fail to guarantee insurers the opportunity to earn a fair profit.

Finally, until now, each state has determined its own MLR by examining the realities of the insurance market in the state. Specifically, "[s]tate-imposed medical loss ratio requirements have varied widely. They reflect differences in rural and urban markets as well as in mar-

166. *See* Geeslin v. State Farm Lloyds, 255 S.W.3d 786, 794–95 (Tex. App. 2008) ("We note, however, that rates can be confiscatory without necessarily leading to insolvency. Thus, the proof provision set out in [the statute], by allowing for the imposition of confiscatory rates, fails to provide regulated companies with a constitutionally adequate review of government-set rates. We therefore hold that the proof provision is unconstitutional on its face.").

167. *See supra* Part II.C.1–2.

kets that have different levels of competition."[168] In other words, each state bases its MLR requirement on the actual circumstances prevailing in the state's insurance market. This is the constitutionally-proper method for setting insurance rates. In contrast, the federal government set the ACA's MLR requirement based on political calculations, not by analyzing the economic realities of the insurance markets around the country. This "one size fits all approach" creates a constitutional concern.

III. Mandatory MLR in the Health Insurance Industry: Bad Policy?

A. Policy Arguments Favoring a Mandatory MLR

Notwithstanding the constitutional problems of the ACA's MLR provision, Congress had valid reasons to believe that setting a mandatory, nationwide MLR for the health insurance industry made good sense. The ACA's statutory language indicates that Congress tried to accomplish several competing policy goals through the minimum MLR requirement: participation by insurance providers, competition among insurance providers, and value for health insurance consumers.[169] Of these three goals, ensuring that consumers get "value for their premium dollar" reigned supreme during the health-care debate.[170] Specifically, ACA supporters in Congress claimed that the MLR requirement would reduce insurance companies' administrative costs and stop executives from getting rich at the expense of the American consumer. Legislators advocating for the ACA uttered this mantra over and over, using slightly different words to convey the same basic concept: insurance companies are greedy and wasteful, and the MLR requirement will rein them in. The following quotations are exemplary of the debate:

168. Haberkorn, *supra* note 46.

169. ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 887 (2010) (discussing the factors states should consider when deciding whether to raise the MLR above federally mandated levels) (amending Public Health Service Act § 2718(b)(2), codified as amended at 42 U.S.C. 300gg-18).

170. *See* 157 CONG. REC. H266 (daily ed. Jan. 19, 2011) (statement of Rep. Rush D. Holt) (claiming that the ACA will secure adequate health care service to almost all Americans because it requires health insurance companies to "spend . . . premium dollars on actually providing health care"); 157 CONG. REC. H267 (daily ed. Jan. 19, 2011) (statement of Rep. John F. Tierney) (noting that, due to lack of regulation, insurance companies went from spending 95% of all premium dollars in health services in 1993 to 60% in 2008, and arguing that the MLR will reverse this trend by requiring insurance companies to invest premium dollars in actual health services).

This provision provides the Commissioner with the authority to ensure that premiums are used primarily to provide health benefits and not lost to excessive administrative costs or profit.

—Report on the Committee on the Budget, House of Representatives[171]

Without a minimum medical loss ratio to hold insurance companies accountable there is no limit on the amount of taxpayer resources that private health insurance companies can spend on executive compensation, shareholder profits, marketing, and other activities that do not add value for the consumer.

—Representative John D. Rockefeller, IV[172]

What a novel idea; you get some bang for your buck and the government would actually do something for you for a change, protecting consumer rights and making sure that companies do what they should be doing.

This isn't about profits. The companies are extremely profitable, and this is not going to cramp their style. In fact, *this is about greed.*

—Representative John Tierney[173]

[The bill] will require all insurers to reinvest more of our premiums back into health coverage through a "medical loss ratio" of at least 80 percent, ensuring that no more than 20 percent of our premiums go toward administrative expenses and *windfall profits for insurance executives.*

—Representative James R. Langevin[174]

This is going to make health insurance companies put at least 85 percent of their premiums toward actual health services, not administrative costs, marketing campaigns or profits or *bloated CEO salaries.* Advocates have been trying to get these profit restrictions in place in many States, but it is usually too hard to fight these companies on a local level. So while I am disappointed we don't have the public option, the minimum medical loss ratio is a potent measure that will limit insurers' profits and put the brakes on *skyrocketing premiums.*

—Senator Al Franken[175]

171. H.R. REP. NO. 111-443, vol. I, at 214 (2010), *reprinted in* 2010 U.S.C.C.A.N. 127, 138.

172. S. REP. NO. 111-89, at 434 (2009) (views of Rep. John D. Rockefeller IV et al.).

173. 157 CONG. REC. H1261 (daily ed. Feb. 18, 2011) (statement of Rep. John Tierney) (emphasis added).

174. 156 CONG. REC. H2432 (daily ed. Mar. 25, 2010) (statement of Rep. James R. Langevin) (emphasis added).

175. 155 CONG. REC. S13817 (daily ed. Dec. 23, 2009) (statement of Sen. Al Franken) (emphasis added).

These worries have some factual basis. As mentioned above, health insurance premiums continue to rise much too quickly, e.g., by 20% or more from 2010 to 2011.[176] On the other hand, health insurance companies typically operate on a relatively low profit margin. The health insurance industry profit margin is 2.2%, which pales in comparison to the profit margins in other health-related industries such as pharmaceuticals (19.3%) and medical products (16.3%).[177] Additionally, a similar study shows that health insurance companies' profit margins vary quite a bit across the industry, from a high of 7.3% for WellPoint to a low of -0.3% for Health Net.[178]

Imposing a profit cap on a low-profit margin, heterogeneous industry does not make much economic sense. If the health insurance industry suffers from anti-competitive tendencies, then increasing competition will solve the problem. In that regard, the ACA's health insurance exchanges should enhance competition in the health insurance marketplace. With greater competition, the MLR requirement becomes redundant at best and harmful at worst, for all the reasons set forth in Part III.B. below.

B. Policy Arguments Against a Mandatory MLR

As discussed in Part I.A., the ACA's MLR requirement acts to cap profits in the health insurance industry. Economists have long condemned profit caps and other government price controls because they reduce quality and distort the allocation of resources.[179] Opponents of the MLR requirement have adapted and expanded these general "anti-price control" arguments to the MLR context.

Some critics believe that requiring insurance companies to meet a high MLR standard will drive many insurers out of the market, thereby reducing competition and consumer choice.[180] Different regions have different demographics, costs of living, average salaries, and so forth, so the administrative costs to run a health insurance bus-

176. Pear, *supra* note 96.

177. *Fortune 500, Top Industries: Most Profitable*, CNNMONEY (May 4, 2009), http://money.cnn.com/magazines/fortune/fortune500/2009/performers/industries/profits/.

178. *Fortune 500, Industries*, CNNMONEY.COM (May 3, 2010), http://money.cnn.com/magazines/fortune/fortune500/2010/industries/223/index.html.

179. Rockoff, *supra* note 100, at 409–10.

180. *See, e.g.*, Haberkorn, *supra* note 46 ("If the medical loss ratios are overly stringent, companies and many state commissioners are concerned that insurers will leave markets with too few enrollees to make it worthwhile, leaving consumers with few coverage options. They also fear that small insurers will be driven out of business because the requirements don't account for market volatility from one year to the next.").

iness will inevitably vary throughout the country. Some insurance providers in high administrative cost markets may not meet the 80% or 85% MLR requirement and will have to exit the markets, or so the argument goes. According to Congressman John Carter (R-Texas), "[i]ndustry analysis estimates that as many as 47 percent of the participants in individual and small group plans which have higher administrative costs due to economies of scale will lose their health insurance if [the MLR] regulation becomes law."[181] Similarly, the CBO worries that the health insurance industry's response to the minimum MLR law "would reduce the types, range of prices, and number of private-sector sellers of health insurance."[182]

These concerns apply with particular force to small insurance companies because the MLR requirement hits these small businesses especially hard. Although the ACA's MLR provision differentiates between the sizes of the group insured (80% MLR for small groups and individuals and 85% MLR for large groups), the law does not distinguish between large and small insurance providers. This is problematic because small companies typically have higher administrative costs (on a percentage basis) than larger companies do.[183] As Merrill Matthews of the Institute for Policy Innovation puts it, "[t]he MLR is nothing but a price control mechanism that will drive even more of the smaller and medium-sized insurers out of the market, dramatically reducing competition. That's in part because large insurers have better economies of scale to keep administrative costs lower."[184] If the MLR requirement puts small insurers out of business, large insurance companies will face less competition and, therefore less pressure to keep prices down.

The MLR requirement has real potential to cause insurance companies to exit certain markets. In Maine, one low cost insurer that covers over 30% of the people in Maine's individual insurance market "said it may exit the market if required to meet this higher [MLR] standard in 2011 and 2012."[185] Similarly, Nevada claimed that three insurers "have imposed moratoriums on new business while they de-

181. 157 CONG. REC. H1651 (daily ed. Mar. 9, 2011) (statement of Rep. John Carter).

182. *See Budgetary Treatment*, *supra* note 158.

183. *See* Merrill Matthews, *Rolling Back ObamaCare: Eliminate the Medical Loss Ratio*, FORBES BLOGS (Jan. 18, 2011, 12:42 AM), http://blogs.forbes.com/merrillmatthews/2011/01/18/rolling-back-obamacare-eliminate-the-medical-loss-ratio/.

184. *Id.*

185. *The Maine MLR Adjustment*, *supra* note 67.

termine their ultimate market strategy" and might leave the Nevada market if HHS fails to grant the state's MLR adjustment request.[186]

A second argument against the ACA's MLR provision focuses on the law's likely detrimental effect on insurance brokers. If insurance companies must reduce administrative costs to comply with the heightened MLR requirement, then insurers have a strong incentive to cut broker commissions. This is one reason why brokers lobbied to keep their commissions out of the MLR calculation.[187] If insurers cut payments to brokers, some brokers will go out of business entirely, and others will simply stop selling health insurance. If this happens, then the health insurance market, and in particular the consumers, will lose the benefits that brokers bring to the table (insurance plan design, implementation, explanation, troubleshooting, and claim resolution).[188] Congressman Tom Price of Georgia expressed this very concern: The MLR requirement "compromise[s] the opportunity for brokers to provide the best advice to citizens . . . . [T]hese folks are going to be pinched and pushed out of their jobs, the ones that are actually helping our citizens to weave their way through the morass of health coverage in this country."[189]

Third, an MLR requirement paternalistically deprives consumers of the freedom to choose the kind of health plan they want. Some insurance companies have high MLRs, and some have low MLRs.[190] Assuming that low MLR plans spend more on plan administration, and higher administrative costs result in better customer support, claims processing, client service, and so forth, some rational consumers may prefer low MLR plans. The ACA's MLR requirement effectively eliminates these kinds of plans.

The fact that insurance companies operate over a wide range of MLRs supports the proposition that consumers have heterogeneous preferences when it comes to the MLR, or at least the variables that constitute the MLR. In 2005, the six largest for-profit insurance com-

186. Letter from Brett J. Barratt, Nev. Comm'r Ins., to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs., at. 3 (Feb. 9, 2011) (citations omitted), http://cciio.cms.gov/programs/marketreforms/mlr/states/nevada/mlr_letter_to_sec_sebelius_2_9_11.pdf.

187. *See* Haberkorn, *supra* note 46 ("Insurance agents and brokers wanted their commissions to be excluded from medical loss ratio calculations because of concern that insurers would cut their pay to improve medical loss ratios.").

188. *See* CONWELL, *supra* note 47, at 3 (explaining the benefits that insurance brokers bring to employers and insurance plans).

189. 157 CONG. REC. H1261 (daily ed. Feb. 18, 2011) (statement of Rep. Tom Price).

190. *See supra* note 164 and accompanying text (indicating that in 2009 MLR ratios ranged from 68.1% to 88.1% in the individual market, from 78.2% to 92.1% in the small group market, and from 88.2% to 87.2% in the large group market).

panies had MLRs ranging from 76.9% (Aetna) to 83.9% (Health Net).[191] In 2010, the five top health insurance companies in Kansas had the following MLRs: American Medical Security, 97%; Blue Cross Blue Shield of Kansas, 93%; Blue Cross Blue Shield of Kansas City, 91%; Coventry, 72%; and Time Insurance Company, 57%.[192] This kind of variety is good, but the ACA obviously considers it to be a problem.

On a more basic level, not all low MLR plans are "bad" and not all high MLR plans are "good."[193] For instance, Aetna remained popular in 2005 despite its relatively low MLR.[194] Some consumers are obviously willing to pay a higher price for higher quality. The ACA should not discourage that.

Fourth, this new federal MLR regime will be extremely complicated and expensive to administer. The implementing regulations are seventy-two pages long and contain elaborate guidelines.[195] Despite the length and detail of these regulations, insurance providers will still have difficulty determining exactly what expenses to include where in the MLR calculation because the definition of its components is inherently vague. For example, a non-claim expense must be "designed to improve health quality," and "to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements," for a health insurance issuer to count this expense as a quality improvement activity within the MLR calculation.[196] Similarly, activities that "[e]nhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology" are considered to improve health care quality and used in the calculation of the MLR, whereas those that are "designed primarily to control or contain costs" are excluded from this definition.[197] These regulations fail to define with precision important com-

191. Jonathan G. Bethely, *Health Plans Make More, Spend Less in 2005*, AMERICAN MEDICAL NEWS, Mar. 6, 2006, at 30, *available at* http://www.ama-assn.org/amednews/2006/03/06/bisd0306.htm.

192. Ranney, *supra* note 165.

193. *See generally* discussion *infra* Part III.C.

194. *Cf.* Bethely, *supra* note 191, at 30 tbl.1 (showing that in 2005, Aetna's revenue increased 13% from the previous year, despite having a 76.9% MLR, the lowest in the industry for that year).

195. *See* MLR Regulations, *supra* note 35, 75 Fed. Reg. 74,864 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158), *available at* http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf.

196. *Id.* at 74,875.

197. *Id.* at 74,924.

ponents of the MLR ratio, such as quality improvement activity. Businesses need clear guidance to plan their affairs, and the MLR regulations do not deliver.

This complexity and ambiguity will cause several problems. First, health insurance companies will spend much time, energy, money, and human capital trying to understand and comply with the nuanced regulations. Insurers would better spend these resources on something else, e.g., covering the costs of a patient's surgery. Additionally, overly complex and/or vague laws such as the ACA's MLR provision are ripe for abuse. Opportunistic insurance providers will seek out ways to circumvent the law by artificially inflating their MLRs or finding "loopholes" in the regulatory scheme. Thus, the MLR requirement will likely be less effective than its supporters hope.

Finally, the ACA's MLR provisions will arguably discourage health insurance companies from investing in innovation. Innovating is expensive. If a company spends money to develop technology that counts as "administrative," such as an improved billing system or better claims processing software, the company will have a harder time meeting the MLR requirement. Thus, the company will be less enthusiastic about developing the new technology in the first place. Additionally, since the MLR provisions cap a company's profits, the company has little incentive to go above-and-beyond what is necessary to meet the MLR. Merrill Matthews explores this reasoning through a hypothetical:

> Suppose a new preventive care therapy emerges that makes patients very healthy. Where is the economic incentive for insurers to adopt that therapy if they will be penalized for claims dropping below the MLR?
>
> Suppose new software becomes available that would lower an insurer's claims by catching fraud. But buying the software adds to its limited admin allowance, while reducing fraud lowers the insurer's claims costs. Either way, it could be forced to pay the rebate penalty.[198]

At this point, one should realize the difficulty in classifying the MLR law as normatively good or bad policy. As with most tough issues, both sides of the debate make persuasive arguments that cut in opposite directions. The next Part addresses the effect of a phenomenon called "anchoring," another policy concern that may tip the scales against the ACA's MLR provision.

198. Matthews, *supra* note 183.

C. Anchored to the MLR

Psychologists use the generic term "cognitive bias" to describe "any of a wide range of observer effects identified in cognitive science and social psychology including very basic statistical, social attribution, and memory errors that are common to all human beings."[199] In layman's terms, cognitive biases are mental errors that influence our beliefs and decisions, potentially to our detriment. Anchoring is one kind of cognitive bias.[200]

Anchoring describes "the common human tendency to rely too heavily, or 'anchor,' on one trait or piece of information when making decisions."[201] In practice, the anchoring theory posits that "different starting points yield different estimates [end points], which are biased toward the initial values."[202] The following example illustrates the anchoring phenomenon. Suppose Seller X decides to sell his house. He lists it for $500,000 and waits for offers. Buyer Y likes the house and begins negotiating the price with Seller X. Because Seller X set the price at $500,000, the negotiations revolve around that number. In other words, $500,000 acts as an anchor in the parties' minds during the negotiation. After several rounds of offers and counteroffers, the parties settle on $480,000.

Now suppose Seller X had initially listed the same house for $600,000. Buyer Y still likes the house, but believes the price is way too high. Nonetheless, Buyer Y enters into negotiations with Seller X, hoping to drive the price down. $600,000 acts as the new anchor point, and the parties negotiate around that number. The parties finally agree on a price of $520,000. The higher starting point ($600,000, instead of $500,000) results in a higher end point ($520,000, instead of $480,000) due to anchoring. This powerful cognitive bias influences real-world negotiations[203] and pricing strategies.[204]

199. *Cognitive Bias*, SCIENCEDAILY, http://www.sciencedaily.com/articles/c/cognitive_bias.htm (last visited Apr. 16, 2011).

200. *See* Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 SCI. 1124, 1128, 1230 (1974) (describing three different types of cognitive biases, including anchoring).

201. *Anchoring Bias in Decision-Making*, SCIENCEDAILY, http://www.sciencedaily.com/articles/a/anchoring.htm (last visited Apr. 16, 2011).

202. Tversky & Kahneman, *supra* note 200, at 1128.

203. *See* Charles B. Craver, *Aspirations, Anchoring, and Negotiation Results*, NEGOTIATOR MAGAZINE (Oct. 2005), http://negotiatormagazine.com/article291_1.html (discussing the effects of anchoring on negotiations).

204. *See* Roger Dooley, *Anchor Pricing Strategies*, NEUROMARKETING (July 18, 2008), http://www.neurosciencemarketing.com/blog/articles/anchor-prices.htm (discussing how marketers can take advantage of irrational anchoring).

The ACA's new nationwide mandatory MLR will act as an anchor to which health insurance companies will gravitate. Importantly, this anchoring will affect *all kinds of insurance providers, both good and bad*, and consumers will ultimately lose. For ease of explanation, this Part labels companies having a high MLR (above 80% or 85%) as "good" and companies having a low MLR (below 80% or 85%) as "bad." In other words, good companies are those that currently exceed the new MLR requirements, and bad companies are those that do not. While this assumption is incorrect for the reasons discussed in Part IV.B., the ACA relies upon it, and so shall this Part when discussing the MLR's anchoring effect.

The ACA introduced new, highly visible anchors into the collective mind of the health insurance industry: an 80% MLR in the individual and small group markets and an 85% MLR in the large group market. How will insurance companies respond? A bad company can respond in one of two ways. First, it could leave the market, deciding that changing its business to comply with the new MLR does not make economic sense. This may be positive for consumers (if the company is indeed bad) or negative for consumers (because it reduces consumer choice). Alternatively, the bad company might change its business practices to comply with the new MLR. Again, this may be positive for consumers (if the company raises its MLR by providing more value and eliminating wasteful expenses), but it may be negative (if the company cuts back on expenses for services that consumers actually want). In any event, the ACA's MLR provisions were clearly designed with the bad companies in mind.

That leaves the good companies. How will the new MLR requirement affect them? Anchoring will cause good providers with high MLRs to drift down towards the anchor point (80% or 85%). For example, suppose Insurance Company Z currently operates at an MLR of 90% and sells only to large groups. In dealing with the new federal MLR regulations and reporting requirements, Company Z becomes acutely aware of the mandatory 85% MLR in the large group market. Consequently, the company changes its business practices (reimbursement rates, salaries, administrative expenses, etc.) either consciously, to increase profits, or subconsciously, because 85% is the new magic number. Over time, Company Z's 90% MLR becomes 88%, or 86%, or 85%, because the federal law requires this percentage.

This particular anchoring phenomenon would not pose much of a problem in an insurance industry filled with bad companies. In other words, without good companies in the current market, down-

ward anchoring becomes irrelevant. But the individual, small group, and large group markets include both bad companies (68% MLR, 78% MLR, and 83% MLR, respectively) and good companies (88% MLR, 84% MLR, and 88% MLR, respectively).[205] And since the health insurance industry is heterogeneous, filled with both good and bad companies, downward anchoring poses a real danger to consumers.

Nothing indicates that Congress considered this potentially negative consequence when passing the ACA. Congress likely recognized that different insurance companies had different MLRs, some higher than others.[206] However, as recounted in Part III.A., ACA supporters focused the MLR debate on bad companies and ignored the impact on good companies. Put differently, Congress hoped that a minimum MLR would transform an industry comprising good and bad companies into one containing only good companies (or at least some good companies and some "average" companies). In reality, the MLR mandate may homogenize the health insurance industry as companies anchor themselves to the new MLR. Average insurance providers will glut the market, replacing both good and bad companies. Normatively, one can question whether this market homogenization benefits consumers. Descriptively, anchoring suggests that it will occur.

Critics of this approach may point out that if anchoring to the MLR really exists, insurance companies should have anchored to the existing state-based MLR benchmarks. Yet, many states already have MLR requirements, but the health insurance industry remains heterogeneous and contains both good and bad companies. This challenge has some appeal but ultimately fails. Unlike the ACA's unitary nationwide MLR, state MLR requirements vary widely from state-to-state. For example, "North Dakota requires a 55 percent medical loss ratio for insurers in the individual market, and New Jersey requires an 80 percent ratio."[207] These divergent requirements do not provide a fixed, stable anchor to tether the insurance industry's thinking. The anchoring effect of multiple, conflicting state regulations is lower than that of the ACA's single, nationwide MLR requirement. Additionally, state insurance regulations are based on the prevailing market conditions in the state. Therefore, when compared to a federal statute like the ACA, state-mandated MLRs are much more likely to change from

205. *See supra* note 164 and accompanying text.

206. *See* 155 CONG. REC. S13626–27 (daily ed. Dec. 20, 2009) (statement of Sen. Bill Nelson) (discussing the MLRs of different health insurance providers).

207. Haberkorn, *supra* note 46.

year-to-year. This uncertainty and instability lessens the anchoring effect of state MLR requirements vis-à-vis the federal MLR provisions.

Congress itself implicitly expressed concern with anchoring in the ACA, albeit in a different context. Specifically, the government included a "maintenance of effort" ("MOE") requirement in the ACA's Medicaid/CHIP provision. This suggests that Congress worries about anchoring or, more concretely, regression to new federal government healthcare mandates.

Under the ACA, states must maintain Medicaid and CHIP eligibility levels for children above 133% of the federal poverty level ("FPL").[208] The Georgetown University Center for Children and Families describes the MOE requirement as follows:

> Today, nearly all states provide Medicaid and/or CHIP coverage to children up to 200 percent of the FPL [federal poverty level], with 25 states covering children at or above 250 percent of the FPL. As a condition of receiving federal Medicaid funding, *states cannot scale back their income eligibility levels and enrollment procedures* in place on March 23, 2010 for children eligible for Medicaid and CHIP.[209]

In other words, there are currently good states (those that cover children up to a high percentage of the FPL) and bad states (those that cover children only to a low percentage of the FPL), just like there are good insurance companies and bad insurance companies in the MLR context. The MOE requirement prevents the good states from scaling-back their coverage levels to the new ACA-mandated level (133% of FPL). This means that the MOE protects against anchoring by requiring the good states to stay good. If Congress was not concerned about regression or backsliding by good states, Congress would have no reason to insert the MOE provision in the ACA. Obviously, Congress *is* concerned that the ACA's new requirements will anchor even good actors. However, Congress did not include an anti-anchoring MOE provision in the MLR section of the law. The ACA does not prevent good insurance providers from backsliding, so the new MLR requirements may not work as well as ACA supporters hope.

IV. Implementing the MLR

The ACA's MLR requirement may be unconstitutional and unwise, but it is the law. This Part provides recommendations to insur-

208. *Summary*, *supra* note 8, at 3.
209. *Id.* (emphasis added).

ance companies, state governments, and the federal government on how to best implement the MLR requirement.

A. Insurance Companies

The ACA changes the way insurance providers must calculate and report their MLRs.[210] Companies will not be comfortable with the new requirements right away; it will take some time. To shorten the learning curve, a company should designate certain employees as "MLR experts" and task those individuals to learn the new law inside-and-out. As discussed above,[211] many states imposed MLR requirements on health insurance companies long before the ACA. If a company already has an established MLR compliance department, then it should draw the MLR experts from this department. These individuals have experience dealing with MLR issues in general, so they will be best suited to navigate through the new federal regulations. Additionally, large insurance companies may hire outside counsel or a health care consultant to work on MLR-related issues that are too complex or controversial to handle internally.

Second, management will need to decide whether to adjust the company's business practices in response to the MLR requirements, and if so, how. In low MLR companies, managers will have some tough choices to make. According to the CBO:

> Insurers operating at MLRs below such a minimum would have a limited number of possible responses. They could change the way they provide health insurance, perhaps by reducing their profits or cutting back on efforts to restrain benefit costs through care management. They could choose to pay the rebates, but if they raised premiums to cover the added costs they would simply have to rebate that increment to premiums later. Alternatively, they could exit the market entirely.[212]

Managers of high MLR companies should consider what changes they can make to improve their businesses while still keeping their MLRs above the 80% or 85% threshold.

Third, low MLR companies facing a tough transition may try lobbying their respective states to seek an MLR adjustment from HHS. The ACA's implementing regulation permits only the states, not the

210. *See generally* MLR Regulations, *supra* note 35, 75 Fed. Reg. 74,864 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158), *available at* http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf (implementing MLR requirements for health insurance providers pursuant to the ACA).

211. *See supra* Part III.C.

212. *Budgetary Treatment*, *supra* note 158.

insurance providers, to request an adjustment to the MLR.[213] Therefore, insurance companies need the states' help to get relief. This strategy worked in Maine. MEGA, a large insurance provider in the state, warned that it might leave Maine's individual health insurance market if forced to meet the ACA's strict MLR requirement.[214] Maine subsequently petitioned HHS for an MLR adjustment, and HHS granted the request.[215]

B. State Governments

State governments have several important decisions to make when it comes to the federal MLR. First, a state must decide whether to request an MLR adjustment from HHS.[216] In deciding whether to seek an adjustment, a state should evaluate and weigh the interests of all the parties affected by the new MLR law, including insurers, brokers, and consumers. The state should publicly solicit comments from all interested parties to obtain the information necessary to appropriately balance the interests involved. Of course, the state should be wary that self-interested parties may make groundless claims in order to influence the state to pursue a course of action that favors the party but hurts the state as a whole. If, after balancing the interests, the state determines that raising the minimum MLR will do more harm than good ("destabilize the market"), then the state should petition HHS for an MLR adjustment.

Second, a state must determine whether to increase the state's minimum MLR above the federally mandated level. The ACA gives each state the option to raise its own minimum MLR requirements above the federal benchmarks.[217] Congress directs the states to "seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements" when determining the appropriate MLR.[218] In other

213. *See supra* note 155 and accompanying text (indicating that the ACA provides states with up to three years to request a MLR adjustment).

214. *The Maine MLR Adjustment*, *supra* note 67.

215. *See supra* note 29 and accompanying text (indicating that Maine's MLR adjustment request was granted on March 8, 2011).

216. *See supra* note 28 and accompanying text (indicating that as of September 12, 2011, sixteen states have requested MLR adjustments).

217. ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 886 (2010) (amending Public Health Service Act § 2718(b)(1)(A), codified as amended at 42 U.S.C. 300gg-18).

218. *Id.* (amending Public Health Service Act § 2718(b)(2), codified as amended at 42 U.S.C. 300gg-18).

words, a state should consider the health insurance marketplace in its entirety when setting an MLR. As with the MLR adjustment decision, the state should gather as much information as possible, balance the interests involved, and choose the best course of action for the state as a whole.

C. The Federal Government

The federal government can, and should, do several things with respect to the MLR. First, the government should act quickly on state petitions for MLR adjustments. So far, HHS's performance on this front leaves much to be desired. Of the seventeen requests for MLR adjustments, ten remained pending as of September 12, 2011.[219] HHS received Nevada's request on February 9, 2011, and more than two months later, the application was still undergoing review for completeness.[220] The longer HHS takes to decide these MLR adjustment petitions, the more likely it becomes that insurance companies will leave the market. This market destabilization will hurt health insurance consumers. Substantively, HHS should generally defer to a state's determination that the new federal MLR standard will destabilize the market in the state. The federal government is new to the health insurance business, and each state presumably knows its own insurance market better than the federal government. Thus, HHS should grant the vast majority of state MLR adjustment requests, absent a compelling reason not to.

Second, the federal government should release a short, clear "cheat sheet" summarizing the most important aspects of the new MLR regulations. As mentioned above, the MLR regulations are long, complicated, and ambiguous. Insurance companies and state regulatory agencies need time to decipher the complex MLR requirements. In the interim, a cheat sheet will help those affected by the new MLR to formulate and implement an ideal short-term course of action (e.g., through changed business practices and new statewide regulations).

Finally, Congress should seriously consider repealing the ACA's MLR provision. It is constitutionally troublesome and a bad policy

219. *See supra* note 33 and accompanying text.

220. *See* Letter from Gary Cohen, Acting Dir. Office of Oversight, Ctr. for Consumer Info. & Ins. Oversight, to Brett J. Barrat, Nev. Comm'r Ins. (Apr. 25, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/nevada/nv_app_complete_4-25-11.pdf (declaring Nevada's application complete and setting a deadline of 30 days to issue a decision regarding Nevada's MLR adjustment petition).

judgment. As a practical matter, Congress will not likely pass a stand-alone amendment to eliminate the MLR requirement. However, if ACA opponents succeed in forcing significant changes to the law, hopefully the MLR provisions will be on the chopping block. Alternatively, if the courts strike down the ACA as unconstitutional (e.g., because of the Act's individual mandate) Congress should leave the MLR requirement out of any new healthcare reform legislation.

Conclusion

The United States desperately needs healthcare reform, and the ACA provides it. In that regard, the ACA is a spectacular triumph. The ACA will drastically improve many aspects of our broken healthcare system by increasing competition (e.g., through the health insurance exchanges) and covering more people (e.g., by expanding Medicaid). The ACA is better than nothing, but it is not as effective as it could be, and the MLR requirement embodies the worst aspects of the law: unconstitutional government intervention into private businesses to the detriment of both health insurance companies and American consumers.